Healthcare Reform – A Way Out Or A Way Forward?

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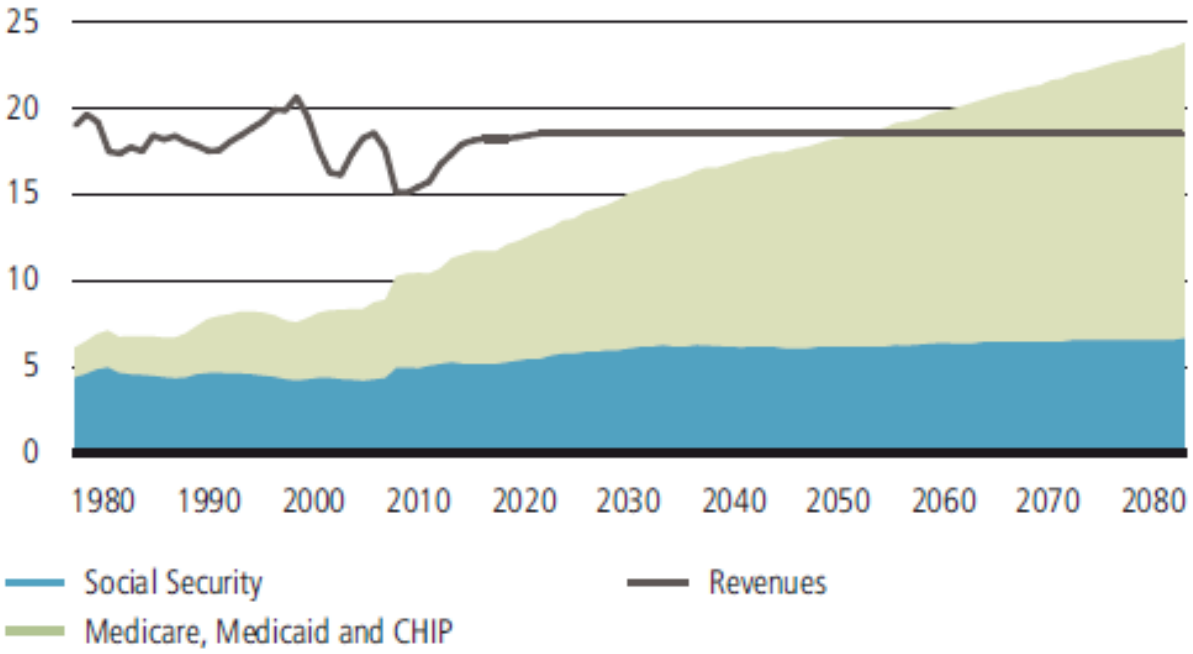
The Federal Government is getting crushed under the cost of entitlement programs. Sovereign debt is at all time highs.

Fig. 10: Entitlement programs to consume all federal revenues

Federal government revenues and entitlement spending as a share of US GDP, in%

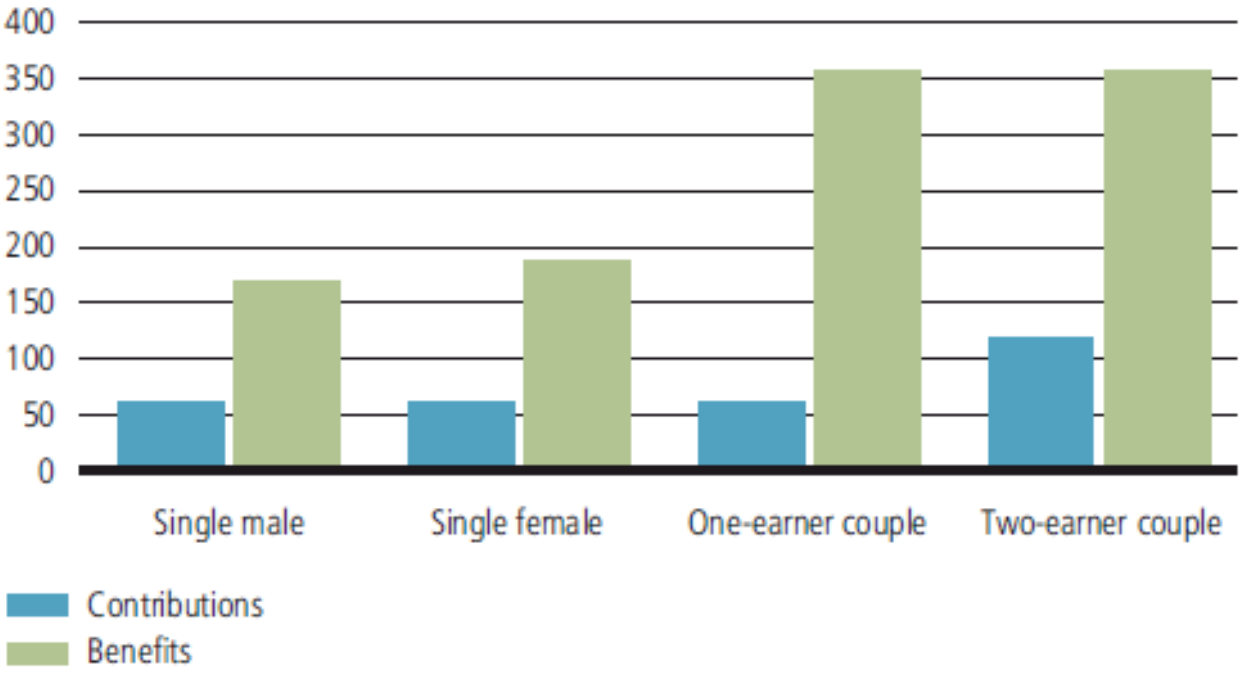


Note: Represents CBO's extended alternative fiscal policy scenario, which assumes a continuation of current policies. CHIP stands for Children's Health Insurance Program
Source: Congressional Budget Office, UBS WMR, as of 2 October 2012

At the time of its inception, Medicare was expected to pay benefits until age 67. Life expectancy is now close to 80. Half of those born after 1980, have a 50% chance to live to be 100 years old. Actuarially, the Medicare Trust is broke!

Fig. 11: American healthcare benefits far exceed contributions

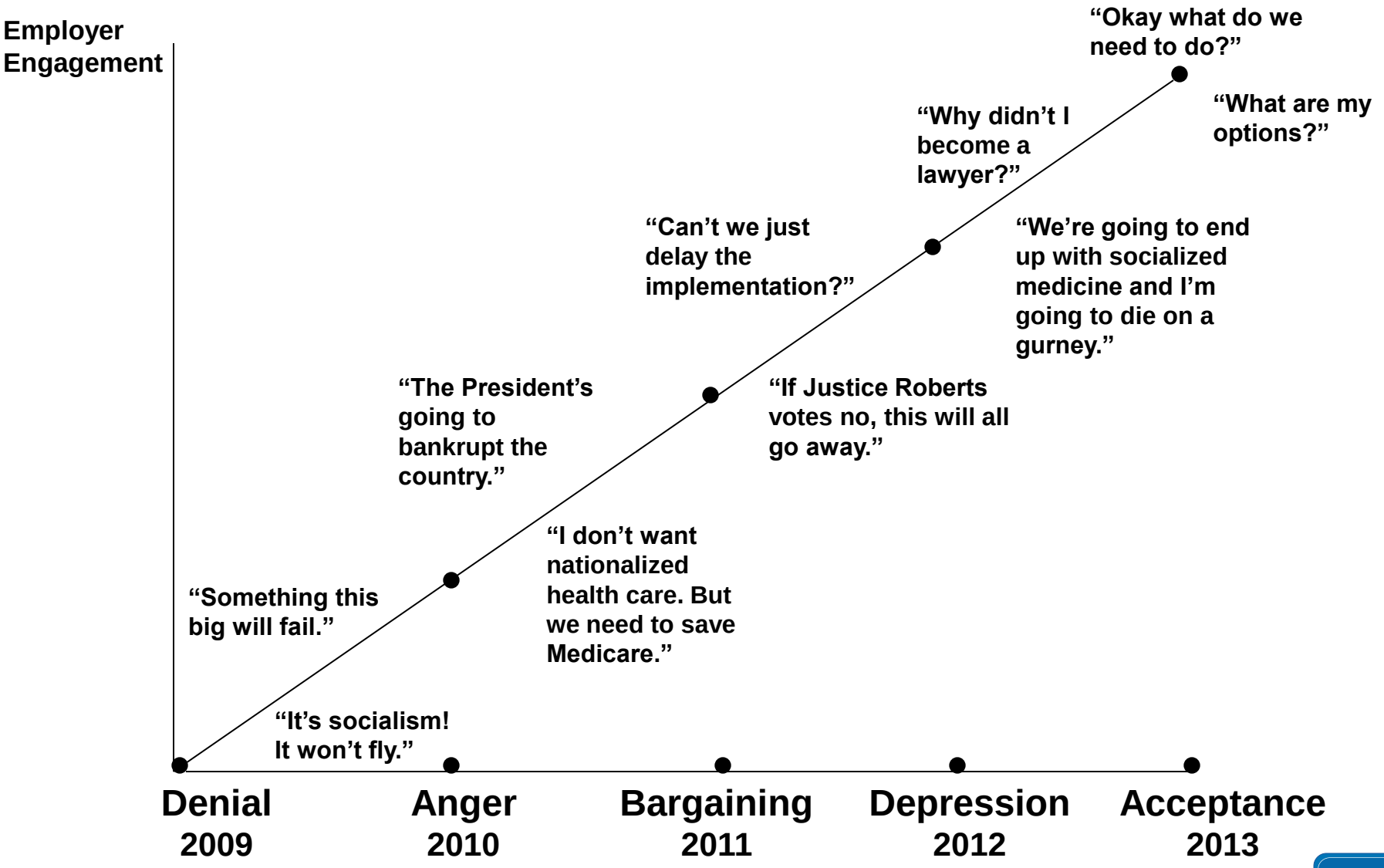
Lifetime Medicare contributions and benefits, in thousands of US dollars, 2011



Note: Assumes retirement at age 65 and an average earner.

Source: Steuerle, Fisher and Rennane, UBS WMR, as of 2 October 2012

The Stages of Death and Dying and Health Reform



Election Recap – Mapping Out The Next Four Years

- Obama retains the White House
- Democrats have majority in the Senate (but not a super majority)
- Republicans retain control of the House

What does it mean?

- Repeal unlikely
- Torrent of guidance and regulations in the coming months
- No delay expected for 2014 requirements
- Legal challenges continue
  - Challenging pieces of the law as opposed to the entire law
- Republicans may try to change smaller pieces of the law through the legislative process (i.e., negotiations on budgetary issues)

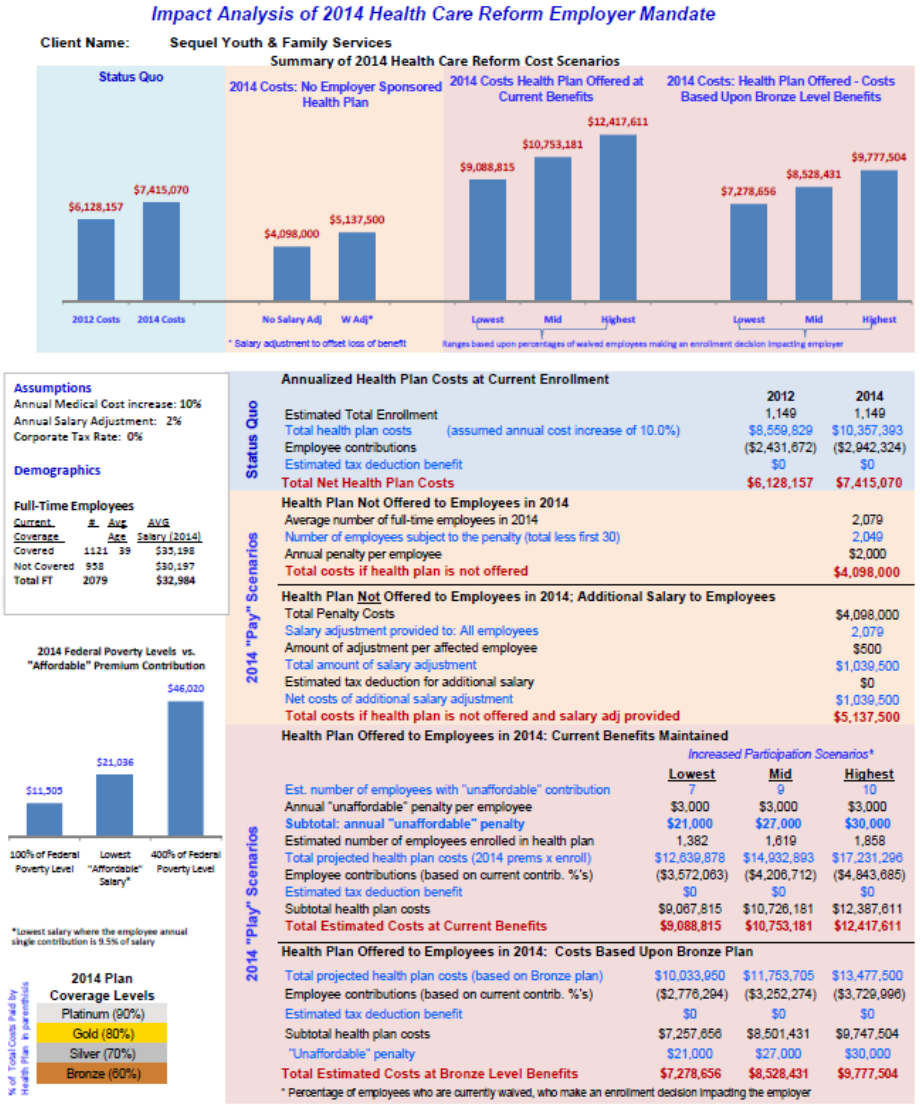
It's Not Going Away!!

Scenario Mapping – Understanding the Impacts and Opportunities of Reform

Impact	Mitigation Strategy
• Current projected employer medical plan costs after employee contribution had health care reform not been passed = $7.4 million	• Offer a less expensive plan that still meets minimum essential coverage requirements
• Cost of dropping the plan and paying the $2,000 penalty = $5.1 million (not deductible)	• The low, medium and high estimates drop to $7.3 million, $8.5 million and $9.8 million respectively

• Costs of Offering Current Plan assuming some percentage of the 930 full time employees currently waiving coverage enroll in the plan
  • At 25% or 233 additional employees now enroll = $9.1 million
  • At 50% or 470 additional employees now enroll = $10.8 million
  • At 75% or 709 additional employees now enroll = $12.4 million
	• Other strategies include contribution restructuring while maintaining total dollars paid by Sequel into the plan

• All employer costs are net of employee contributions and factor in the tax deduction	



Strategic Planning Questions / Considerations

1. Does HCR represent a Challenge or an Opportunity for our organization?
2. Will HCR require us to make significant changes?
   - How we offer benefits?
   - To whom we offer benefits?
   - What benefits we offer?
   - How much the benefits cost?
   - How we administer benefits, payroll, employee communication...?
   - How will our employees and families be affected?
3. How do the revisions required by HCR fit within our own benefits philosophy / strategy?
4. What do we expect other players in our industry will do with respect to HCR?
   - What impact will there be to our competitive position?
   - Do we manage to effect superior results?
5. Should we consider changes to our benefits strategy and overall compensation model?
6. Are we prepared internally to support the changes needed?
7. Do we understand how public exchange will develop in our state? Will plan designs vary dramatically from current commercial plans?

A Splintering Of Employer Attitudes: What's Your Plan?

1. ENGAGEMENT - WE BEND MEDICAL TREND

(We reduce unit cost intensity of services during episodes of core and consumption by driving healthier consumers)

OR

2. DEFINED CONTRIBUTION – A WAY FORWARD USING A SINGLE CARRIER OR GROUP CHASSIS

(Cap employer contributions and absorb a percentage of rising annual costs based on corporate performance)

OR

3. DISENGAGEMENT – A WAY OUT BY PUSHING PEOPLE INTO EXCHANGES

(We create a new "at risk" uninsured class as non subsidy eligible families cannot afford $20k -$25k average premiums for family coverage)

Most industry experts project that 95% of employer's will continue to offer coverage – but how will they manage the rising cost in the near future?

Play

Employer sponsored healthcare	Employer sponsored healthcare & specific public exchange opt-outs
– Can we keep medical trend renewals in low single digits? – What percentage of our operating profit is impacted by healthcare? – How will the delivery system change?	– Can we direct high subsidy eligibles to exchanges? – How will carriers react to participation changes? – How will employers modify plans?
Public exchange opt-out. e.g. Dumping with no subsidy	Private & public exchange supported by defined contribution
– Low margin and low wage businesses will consider. – Many under 100 who favor pure dumping already have exited. – What will the penalty be?	– Profit sharing contributions? – A way forward or a way out? – Affordability will be an issue that will not go away. – Decade of consumerism

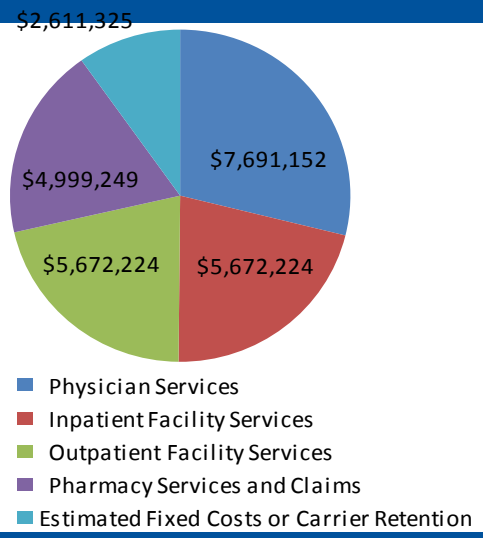
Pay

It is time to engage the C-suite and review why you offer healthcare?

Engagement: USI Cost Driver Audit –Opportunity Preview

Pro Forma Data

Number of Employees on Medical Plan	2,809	
Assumed Annual Composite Cost of Medical	$9,486	
		% of Total
Claims Cost Estimates by Type of Service		
Physician Services	$7,691,152	29%
Inpatient Facility Services	$5,672,224	21%
Outpatient Facility Services	$5,672,224	21%
Pharmacy Services and Claims	$4,999,249	19%
Total Claims	$24,034,849	90%
Estimated Fixed Costs or Carrier Retention	$2,611,325	10%
Estimated Annual Cost of Medical	**$26,646,174**	**100%**



Key Opportunities

USI Initiatives		Savings	% savings	Disruption
Analytics	Network Discount Analysis (currently with TPA)	$ 951,780	4.0%	Low
Ancillary	Dental Discount Analysis	226,808	0.9%	Low
Analytics	High Performance/Tiered PPO Network	404,997	1.7%	Medium
Compliance	Actively Monitor Legislative and Regulatory Developments	7,800	0.0%	Medium
Population Health	Disease management programs (asthma, diabetes, high blood	304,570	1.3%	Low
Pharmacy	Rx Pass Thru Strategy	274,959	1.1%	Low
Analytics	Working Spouse Carve out OR COB Strategy	838,215	3.5%	High
Analytics	Plan Design Modeling with Benchmarking	399,693	1.7%	Medium
HR Services	Cost and quality resource / transparency tools	348,316	1.4%	Low
Pharmacy	PBM average script price RFP - (Risk Transfer Strategy)	274,959	1.1%	Low

3D Functionality - Medical Intelligence Utilization Metrics

Group	SAMPLE CLIENT		
Status	ACTIVE		
Analysis Period	Rolling Year (Feb 12 thru Jan 13)		
		Value	
Metrics	Metric Type	Actual	Norm
ER Visit Utilization			
ER Visits*	Per 1000	206.9	249.7
ER Claimants	Member Per 1000	145.5	166.9
ER Visits per ER Claimant	Average Visits	1.4	1.5
ER Visits resulting in an Admission	% of Admissions	51.9	37.5
ER Visit Paid per ER Visit	Average Paid	$ 1,008.22	$ 1,013.95
ER Visit Allowed per ER Visit	Average Allowed	$ 1,704.54	$ 1,493.56
Inpatient Utilization			
Inpatient Days	Per 1000	276.1	352.9
Inpatient Claimants	Member Per 1000	51.0	77.1
Average Length of Stay	Average Days	5.3	4.8
Total Admissions*	Per 1000	52.3	74.0
Medical Admissions	Per 1000	16.9	24.0
Surgical Admissions	Per 1000	22.0	24.6
Maternity Admissions	Per 1000	11.2	21.2
Behavioral Admissions	Per 1000	2.2	4.2
Total Admission Paid per Admission	Average Paid	$ 22,091.99	$ 15,409.19
Total Admission Allowed per Admission	Average Allowed	$ 23,832.46	$ 19,785.11
Total Admission Paid per Day	Paid per Day	$ 4,182.58	$ 3,231.37
Total Admission Allowed per Day	Allowed per Day	$ 4,512.10	$ 4,149.03
Imaging Utilization			
CT Scan	Per 1000	63.3	72.0
MRI Scan	Per 1000	40.6	72.3
Drug Utilization			
Pharmacy Scripts	Per 1000	8,992.8	11,080.1
Pharmacy Scripts Mail Order	% of Mail Order	17.9	9.5
Pharmacy Scripts Brand Drugs	% of Brand Drugs	21.0	31.0
Office Visit Utilization			
Total Office Visits*	Per 1000	3,313.5	4,011.4
Regular Office Visits	Per 1000	2,599.1	3,019.8
Preventive Office Visits	Per 1000	381.9	440.1
Behavioral Health Office Visits	Per 1000	187.4	415.0
Consultations	Per 1000	114.5	124.1
Other Office Visits	Per 1000	30.7	12.3
Other Utilization			
Chiropractic Visits	Per 1000	163.8	368.2
Physical Therapy	Per 1000	523.5	703.7
SNF Days	Per 1000	5.6	3.8
Deliveries	Per 1000	6.5	14.1
Dialysis	Member Per 1000	1.9	1.5
Transplant	Member Per 1000	0.6	0.7

This group has lower than Norm ER Visits

The inpatient admission following an ER visit is higher than the norm, this is indicative of the population using the ER for the correct reasons.

The group's amount paid per admission is higher than the norm, this would trigger USI to take a deeper dive into the inpatient claims.

This group has better mail order pharmacy utilization than the norm.

The group's preventive care visits are lower than the norm, this would trigger USI to contact the carrier to discuss a mailing to the population to remind them of the importance of such exams. Other office visits are much higher than the norm, with increased preventive visits, the other visits should go down as well.

3D Functionality - Medical Intelligence Quality and Risk Measures – Gaps in Care

Because USI has determined many member have Hypertension, we have drilled down to see if there are any high risks or gaps in care with the hypertension members.

A gap is an area where a member should have received a service but has not. A risk is a member has had a certain event or service that is considered a "riskier" member.

Condition	Is it a Risk or a Gap?	Description	Individual		Actual	Norm
			With Condition	With Gap/Risk		
Hypertension (E)	Gap	Patients without flu vaccination in the last 12 months.	1,057	791	74.83%	81.01%
Hypertension (E)	Gap	Patients without thiazide diuretic in the last 24 months.	1,057	747	70.67%	73.69%
Hypertension (E)	Gap	Patients without diuretics in the last 24 months.	1,057	717	67.83%	69.03%
Hypertension on 2 or more agents in the last 12 months (E)	Gap	Patients without thiazide diuretic in the last 24 months.	544	367	67.46%	62.49%
Patients with Hypertension with at least one additional cardiovascular risk factor	Gap	Patients not receiving medications from at least 2 different antihypertensive drug classes	741	270	36.44%	34.08%
Patients with Chronic Kidney Disease (CKD) stages 1-4 or diabetes mellitus, and hypertension in the analysis period, taking at least 2 prescriptions of ACEI/ARBS in the last 12 months (E)	Risk	MPR for ACE-I/ARBS of < 80% in the last 12 months	266	125	46.99%	33.55%
Hypertension (E)	Gap	Patients without office visit in the last 12 months.	1,057	48	4.54%	2.64%
Hypertension	Risk	Patients with more than one hospitalization in the analysis period.	1,057	43	4.07%	5.69%
CAD and Hypertension (E)	Gap	Patients without antihypertensive drugs in the last 12 months.	85	11	12.94%	13.84%

Of the 1,057 members with Hypertension, 747 of them have not taken a thiazide diuretic in the last 24 months. While this is a "gap" it is possible the member has not been subscribed medication to have the condition controlled as of yet. There are members who may still be in the "diet and exercise" approach to care..

Self Insure: Cost Shifting Will Be More Prevalent Under Insured Plans

- Self insurance could significantly grow in popularity as employers seek:
  - Greater transparency of claims
  - Question bundled insurer practices
    - Capitation payments to subsidiaries such as pharmacy and behavioral health
    - Capitation payments to providers
    - Efficacy of disease management and medical management
    - Discounts
  - Avoidance of fees passed on by insurers
  - Avoidance of state premium taxes
  - Avoidance of state mandates
  - Ability to contract directly with ACO's?

We believe the simple act of self insurance may reduce fully insured costs by as much as 10% by 2014. Employers need to get over their fear of financing their own risks.

Resources Required To Run The Reform Race – Do you have access to these resources now?

- **Communications** – SBC requirements, exchange notification, reform education, plan changes -- what is your theme?
- **Employee advocacy, engagement and education** – Enrollment, plan changes, issue resolution and support – Who will intervene on their behalf?
- **Actuarial / underwriting** – Contribution setting for plan options, scenario modeling, plan option forecasting, budge assumptions and funding analysis – Do you know what your trend goals are and how costs impact profits? Do you understand self insurance?
- **HR Administration** – Do you want to outsource, co-source or contract elements of HR administration to third parties – Are you stuck being tactical when you need to be strategic?
- **Pharmacy** – Carrier and large PBM models are broken. Insurers using rebates to offset their own administration costs – What is your true Rx trend?
- **Compliance** – HR and employment laws will continue to become more complex. ERISA will change and be challenged – Who is your legal resource?
- **Healthcare reform modeling and scenario planning** – Discovery of risk exposures, review of financial exposures, modeling based on employment and design changes – Will reform happen to you or for you?
- **Clinical** – What are the controllable utilization trends in your health plans? Is your carrier fulfilling their administrative duties to impact consumption trends? What current and forecasted cost arising from?
- **Population health** – Premium differentials, incentive plans – Can I change behavior?

Healthcare Reform – Private Exchanges: Cafeteria Plans With Automated Decision Support

What Are Private Exchanges?

- Private Exchanges are single and multi-carrier cafeteria plans with automated decision support tools – Think on-line enrollment on steroids!
  - Should not be confused with Public Individual or SHOP Exchanges
- Private Exchanges are still early stage concepts in the middle market
  - Large vendors have launched an exchange for very large employers
  - Carriers have acquired companies with exchange technology
  - Independent Startups have launched exchanges in the middle market

Option #1 Open Platform

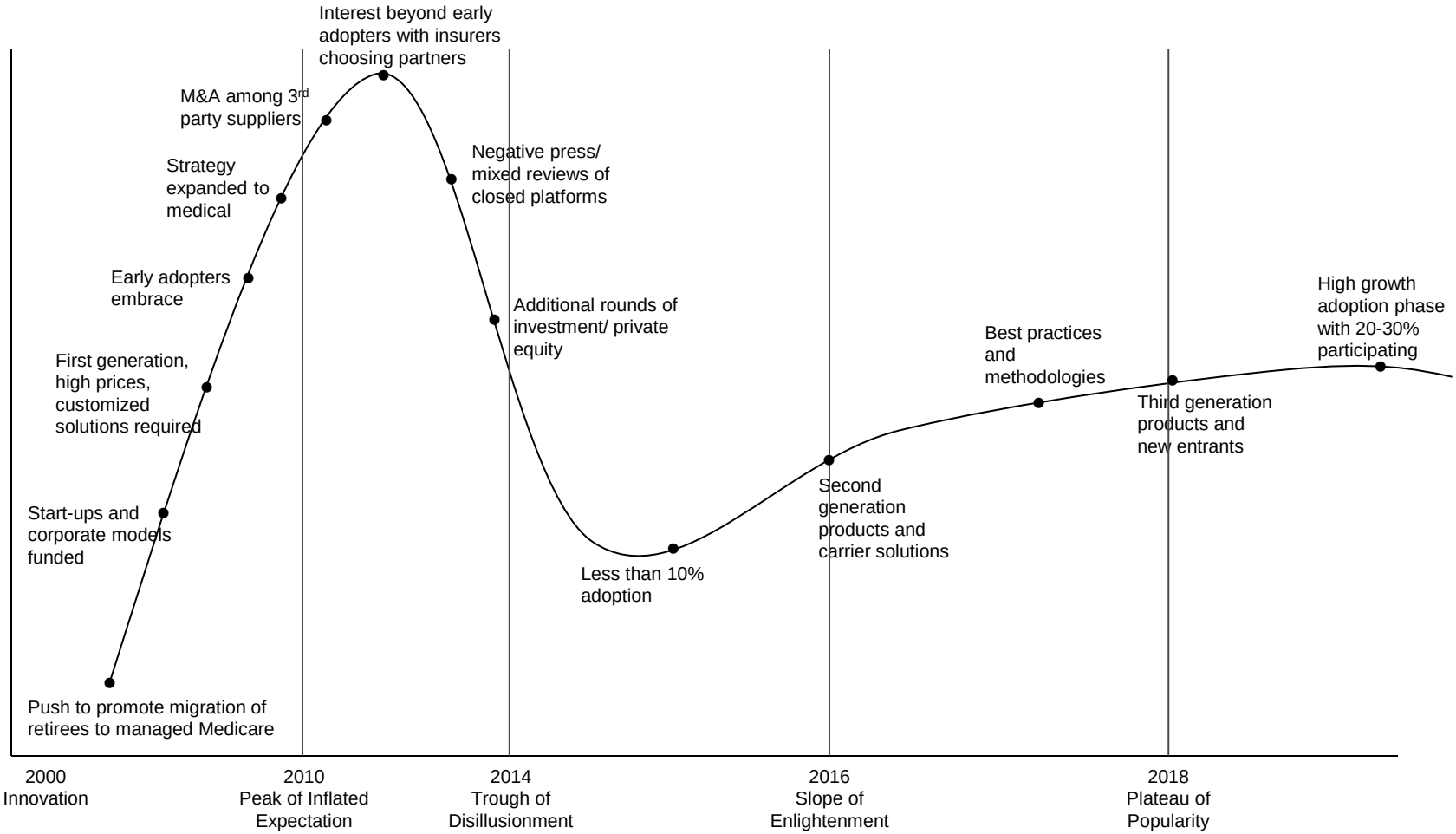
- Middle market brokers will partner with exchange companies
  - Vendors aggressively marketing to discreet broker partners
  - Insurers seeking distribution partner with the technology
- Expect consolidation from vendors and all carriers to announce alliances

Option #2 Proprietary Platform

- Some brokers/consultants will seek to leverage a proprietary private exchange
- If you are looking for "a way out", you may be indifferent to open or closed platforms
- If you are looking for a way forward, most exchanges should be evaluated like on-line enrollment vendors or communications partners. The question will be: How easy will it be to pick a new administrator if the exchanges, administration, pricing or products fail to meet employee expectations? Will you care?

Certain employers will want to evaluate private exchanges using third party vendors or asking their brokers for a proprietary solution. Each firm will need to weigh the attraction of capping expenditures through a defined contribution approach and the strategic and tactical consequences to their plans.

Defined Contribution and Private Exchanges – A Trend Or Hype Cycle?



An exchange is the nail, your strategy is the hammer – not the other way around

Source: Gartner Group Hype cycle indicators model adapted to exchange cycle

You're Not Alone…

- Every employer must make a decision regarding healthcare reform, it's impact on plans and determining the significance the plan plays for attracting and retaining employees.
- Strategy must drive structure.
- Force your C-Suite execs to engage. Brace yourself for a debate with finance.
- Pick your partners carefully, the stakes could not be higher:
  - Question the value of everyone and hold your vendors to measurable standards.
  - Your rate of medical cost growth cannot increase faster than your operating income or margins will be diluted.
  - If growth is flat and margins are under pressure, remember that **it is more disruptive to fire employees than it is to make changes to your plans.**